

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 27, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT Scan of the Lumbar Spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

MD, Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for CT Scan of the Lumbar Spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/17/08, 1/2/09

ODG Guidelines and Treatment Guidelines

Dr. , MD, 5/7/07-12/28/08

Dr. , 12/2/08

Dr. , MD, 10/29/08

Dr. , 11/11/03-5/18/04

Dr. , 12/5/03

Dr. , 4/3/07, 4/9/07

Dr. , MD, 7/13/07, 10/5/07, 2/22/08, 12/2/08
Dr. , MD, 8/2/07, 3/27/08
Notes, 2007-2008
, 10/4/07, 1/23/08
Dr. , MD 1/28/08
Dr. , MD, 12/8/08
Dr. , MD, 11/11/03, 12/8/03

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker initially injured on xx/xx/xx. Apparently the individual was in the company van asleep when the van lost control, swung around, and the claimant was thrown out of the van with injuries to the shoulder, neck, and head. He has been treating with Dr. and complaining of high levels of pain, 10/10. The CT scan is being requested because the injured worker has not had recent imaging studies.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The current request does not give the reviewer or the previous reviewing physicians, a medical reason for an imaging study of the lumbar spine at this time. The previous CT scans and other imaging studies in the records were reported as normal. The medical records do not indicate any change in the neurological status or complaints other than pain. The reviewer has no way of overturning the previous reviewer's adverse determination, as the treating physician has not, in his medical records, or in his requests, explained why the ODG Guidelines and peer review indications should be diverged from in this particular individual's case. It is for this reason that this reviewer must uphold the previous adverse determination. The reviewer finds that medical necessity does not exist for CT Scan of the Lumbar Spine.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**